Standard Form 89

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME: Wichtrich, Alfonso Rudolph 03
2. GRADE AND COMPONENT OR POSITION:
3. IDENTIFICATION NO.:

10 4. HOME ADDRESS: Toluca Highway Klm 19 1/2, El Magueyito, Cuajimalpa, Mexico, D. F.
5. PURPOSE OF EXAMINATION:
6. DATE OF EXAMINATION:

7. SEX: M
8. RACE: White
9. TOTAL YEARS GOVT. SERVICE: MILITARY 6 CIVILIAN 1 1/2
10. DEPARTMENT, AGENCY, OR SERVICE:
11. ORGANIZATION UNIT:

10 12. DATE OF BIRTH: Oct 30 1915
13. PLACE OF BIRTH: Chihuahua, Chih Mex.
14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN: Rae Wichtrich - Wife - Same as above.

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS: 06
16. OTHER INFORMATION: Wt - 185 Ht - 6'3" (2/17/63)

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS (Follow by description of past history, if complaint exists)

Health normal - feel fine - no complaints.

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER			Pneumonia	86
MOTHER			"	76
SPOUSE	46	Normal		
BROTHERS AND SISTERS	53	"		
	52		Tuberculosis	52
	51	"		
	50	"		
			Combat W.W II	33
CHILDREN	22	Excellent		
	19	"		
	14	"		
	12	"		
	8	"		

19. HAS ANY BLOOD RELATION (Parent, brother, sister, other) OR HUSBAND OR WIFE:

YES	NO	(Check each item)	RELATION(S)
X		HAD TUBERCULOSIS	Sister
	X	HAD SYPHILIS	
X		HAD DIABETES	Mother
--		HAD CANCER	
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM (Arthritis)	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY (Fits)	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW (Place check at left of each item)

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
	X	SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TUMOR, GROWTH, CYST, CANCER		X	"TRICK" OR LOCKED KNEE
	X	DIPHTHERIA		X	TUBERCULOSIS		X	RUPTURE		X	FOOT TROUBLE
	X	RHEUMATIC FEVER		X	SOAKING SWEATS (Night sweats)		X	APPENDICITIS		X	NEURITIS
	X	SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PILES OR RECTAL DISEASE		X	PARALYSIS (Inc. infantile)
X		MUMPS		X	SHORTNESS OF BREATH		X	FREQUENT OR PAINFUL URINATION		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	KIDNEY STONE OR BLOOD IN URINE		X	CAR, TRAIN, SEA, OR AIR SICKNESS
X		FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	SUGAR OR ALBUMIN IN URINE		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	BOILS		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE	X		HIGH OR LOW BLOOD PRESSURE		X	VENEREAL DISEASE		X	DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	RECENT GAIN OR LOSS OF WEIGHT		X	LOSS OF MEMORY OR AMNESIA
	X	RUNNING EARS		X	FREQUENT INDIGESTION		X	ARTHRITIS OR RHEUMATISM		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	BONE, JOINT, OR OTHER DEFORMITY		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	LAMENESS		X	ANY DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	LOSS OF ARM, LEG, FINGER, OR TOE		X	EXCESSIVE DRINKING HABIT
	X	HAY FEVER	X		ANY REACTION TO SERUM, DRUG OR MEDICINE		X	PAINFUL OR "TRICK" SHOULDER OR ELBOW		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (Check each item)

YES	NO	(Check each item)	YES	NO	(Check each item)
X		WORN GLASSES		X	ATTEMPTED SUICIDE
	X	WORN AN ARTIFICIAL EYE		X	BEEN A SLEEP WALKER
	X	WORN HEARING AIDS		X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS
	X	STUTTERED OR STAMMERED		X	COUGHED UP BLOOD
	X	WORN A BRACE OR BACK SUPPORT		X	BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION

22. FEMALES ONLY: A. HAVE YOU EVER—

- BEEN PREGNANT
- HAD A VAGINAL DISCHARGE
- BEEN TREATED FOR A FEMALE DISORDER
- HAD PAINFUL MENSTRUATION
- HAD IRREGULAR MENSTRUATION

B. COMPLETE THE FOLLOWING

- AGE AT ONSET OF MENSTRUATION
- INTERVAL BETWEEN PERIODS
- DURATION OF PERIODS
- DATE OF LAST PERIOD
- QUANTITY: ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS? 1

24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS 14

25. WHAT IS YOUR USUAL OCCUPATION? Business Management

26. ARE YOU (Check one): X RIGHT HANDED ☐ LEFT HANDED

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YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF A. SENSITIVITY TO CHEMICALS DUST SUNLIGHT ETC.
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS
	X	D. OTHER MEDICAL REASONS (*If yes, give reasons*)
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)
	X	32. HAVE YOU HAD OR HAVE YOU BEEN ADVISED TO HAVE ANY OPERATIONS? (*If yes, describe and give age at which occurred*)
	X	33. HAVE YOU EVER BEEN A PATIENT (*committed or voluntary*) IN A MENTAL HOSPITAL OR SANATORIUM? (*If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic*)
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)
X		35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (*If yes, give complete address of doctor, hospital, clinic, etc.*) Routine Check-Ups. Dr. Ernesto Chavez, Jr. Reforma 510-102 Mexico, D.F. Mexico 06 10
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL OR OTHER REASONS? (*If yes, give date and reason for rejection*)
	X	38. HAVE YOU EVER BEEN DISCHARGED FROM MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL OR OTHER REASONS? (*If yes, give date, reason, and type of discharge, whether honorable, other than honorable, for unfitness or unsuitability*)
	X	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY FOR PENSION OR COMPENSATION FOR EXISTING DISABILITY? (*If yes, specify what kind, granted by whom, and what amount, when, why*)

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION SUPPLIED BY ME AND THAT IT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY OF THE DOCTORS, HOSPITALS, OR CLINICS MENTIONED ABOVE TO FURNISH THE GOVERNMENT A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSES OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT OR SERVICE.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
Al. R. Wichtrich 03	

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers to items 26 thru 39*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

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